



Review

Assisted suicide in the care of mentally ill patients: The Lucio Magri's case



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ABSTRACT

A year after Mario Monicelli's suicide, the death of another famous person in Italy, Lucio Magri, reawakened the Italian debate on social, ethical and juridical issues in end-of-life decisions. Unlike Monicelli, Lucio Magri decided to end his own life in Switzerland with the help of a physician because his mental illness rendered his life unbearable. Both Monicelli and Magri suffered from a severe depression. The authors analyze the ethical issues regarding the right to die for mentally ill patients and neurological disabled patients, discussing the decision-making autonomy in persons suffering from severe depression. The role of the psychiatry in the management of end-of-life decision requests is considered along with pros and cons of suicide prevention and rationale suicide.

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1. Introduction

On November 29th, 2010 Mario Monicelli, a world-renowned film director, ended his own life tragically by jumping from a window of the hospital in which he was bedridden. Exactly one year later, another important representative of Italian history, Lucio Magri, also decided to put end his own life, but this time with the help of a physician. Lucio Magri was a well-known, left-wing intellectual who had, after belonging to the leading Catholic party in the aftermath of the Second World War, joined the Communist Party, only to distance himself from it 1968, when the Soviet Union invaded Czechoslovakia. He founded the newspaper "Il Manifesto",

a critical voice of left-wing supporters. Both Monicelli and Magri are likely to have been suffering from severe depression.¹

Lucio Magri's death was yet another occasion for Italians to embark upon a heated debate encompassing social, political and religious issues. Magri suffered from severe depression after his wife's death and died from assisted suicide in Switzerland. His case raises the issue of voluntarily ending one's own life because psychiatric illness has rendered it unbearable and one cannot see any prospects for improvement. The ethical issues related to the ending of human life are characterized by complex questions that reflect the very deep meaning of life and death as a sign of human finitude, and the power wielded over life by the subject him/herself as well as by others. This raises, on scientific, moral and legal levels, the question of the lawfulness of "rational" suicide and the true meaning of the prohibition of killing. The patient's right to decide when to die has emerged as a new position that falls between the doctor's desire to preserve life and the patient's right to decide autonomously.^{2–5} Taking into consideration the importance to evaluate whether the decision making process is supported by a valid and conscious will, mental health professionals assume a

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fundamental role in the care of assisted suicide requests advanced by mental ill patients and neurological disabled patients.

2. The Italian legal context

Assisted suicide is prohibited by the Italian law, falling under the crime of incited or assisted suicide provided by article 580 of penal code. According to this article, anyone who determines others to commit suicide or strengthens in others mind the intention to commit suicide or supports, in every way, the execution of the suicide, shall be punished by imprisonment from 5 to 12 years, if suicide occurs.^{f 24} The rule does not distinguish if the assisted suicide is requested on the basis of psychiatry illness or terminally illness. Italian legal system refuses to accept in general the idea that medical performance can be aimed to end a human life. Generally, in the care of situation involving end-of-life decisions, no protection in terms of case law is given to the so-called *right to die*, but only to the *right to die with dignity*, regarded as an expression of the same right to live that accompanies a person in every stage of his/her life from birth to death. The so-called “help/support” to die provided by *failing to do* holds a special place within this context. Comparing to the assisted suicide, withdrawing and withholding life-sustaining therapies raises less legal and ethical conflict if the patients give their consent.^{21,23} Defining the concept of mental capacity to make end-of-life decision is an old issue.⁶ Indeed, on an ethical level, most physicians tend to accept passive euthanasia, justifying it by stating that it spares the patient futile treatment, while active euthanasia is a far more delicate issue. Moreover, common opinion tends to judge the ethical aspects of the issue largely on the basis of voluntariness, it being less interested in how it was implemented.⁷

The prevailing attitude is that the doctor has no obligation to keep the patient alive against his/her will because a doctor's duty is not to prevent death at all costs, but rather to care for and assist the patient. Moreover, according to the Italian Constitution (article 32), treatment must be imposed upon the patient only if a law to this effect exists and if such treatment is in the best interests of the community. In Italian law, active euthanasia is considered an illegal act, and is punished as murder by consent (penal code art. 579) or as voluntary murder (penal code art. 575) with mitigation of punishment for reasons of piety. Matters related to end-of-life decisions (ELD) are not, however, specifically dealt with by the Law. The same rules apply to passive euthanasia cases, though the negative aspects of this issue are perceived as being ethically less serious. To this purpose, the Eurispes data for 2011 reveal that 66.2% of Italians are in favor of euthanasia, with younger patients displaying the highest approval rate (75.3% between 18 and 24 years of age, 70.9% between 25 and 34 years of age, 67.5% between 35 and 44 years of age, 67.7% between 45 and 65 years of age and 53.7% over 65 years of age), while 77.2% of Italians would like a law to be passed on the living will.⁸

An empirical study involving 336 GPs in Italy answered the Euthanasia Questionnaire, designed to assess attitudes toward euthanasia and/or assisted suicide, and the Maslach Burnout Inventory, designed to examine burnout symptoms, has shown that relatively few physicians receive requests for euthanasia or assisted

suicide (11% and 4.5%, respectively), and only a minority of physicians endorse euthanasia and/or assisted suicide. As the public debate about euthanasia and assisted suicide has always been less pronounced in Italy than in other countries, data regarding this issue are somewhat scarce.

3. The case of Magri: the mentally ill and the request to end life

As assisted suicide is a punishable offence according to the Italian penal code, Magri decided to end his life in Switzerland, where organizations that help people who want to commit assisted suicide exist. Magri was a 79 years old person, suffering from a severe depression, in good physical health, not suffering from any painful disease neither from neurological disease. Through the help of a friend physician, Magri chose to die in a private clinic. He was fully conscious, with clear mind and had given informed consent to the procedure, as required by the Switzerland law. The main Italian newspapers reported that Magri tried to end his life two times before his death though with no success, going privately in Switzerland.²⁵ According to the Swiss penal code (art. 115), assisted suicide is only punishable if driven by a selfish motive.^g Although the assisted suicide offered by Swiss associations was initially only provided for terminally-ill patients,^h it has in recent years been extended to people who are ill or mentally ill.⁹ Magri's case is particularly worthy of note because it falls within a topic of national and international legal-scientific interest regarding what possibilities a mentally-ill person has to request and obtain assistance to commit suicide. In other words, is there any difference between the desire to die expressed by a person with a mental disorder or serious depression and the right to self-determination expressed by a person who is fully capable of understanding?

Particularly illuminating is a recent case, which mirrors that of Magri, decided by the European Court of Human Rights.¹⁰ Ernst Haas, a Swiss citizen suffering from a severe bipolar disorder, took his case to court alleging a violation by the Swiss authorities, on both a medical and judicial level, of his right to decide how and when to die, and consequently of the right of respect for private life enshrined in Article 8 of the European Convention on Human Rights (ECHR). He appealed, in particular, against the refusal of psychiatrists to issue the prescription for the lethal drugs he needed to commit assisted suicide. His main complaint was the authorities' failure to respect the right to privacy, which includes the right to self-determination, according to article 8 of the ECHR. Indeed, he claimed that the need to obtain a medical prescription obliged him to adopt a more painful, useless procedure to execute his plans, which prevented the person wishing to commit assisted suicide from obtaining all the means necessary to do so from the public authority.

The Court stated that a person's right to decide how to die is based on a freely formulated and expressed wish. While the will to decide one's own death derives from the right to live and personal

^f Article 580 of Penal Code: “Anyone who causes others to commit suicide or strengthens in others mind the intention to commit suicide or reinforces another's intent to commit suicide, or facilitates it in anyway, shall be punished, if the suicide occurs, by imprisonment ranging from five to twelve years. If the suicide does not occur, he shall be punished by imprisonment ranging from one the conditions indicated in paragraph 1 and 2 of the previous article. Nevertheless, if the above person is younger than fourteen years old or lacks the ability to provide consent, he provisions related to murder apply” (Negri S., 2011).

^g Widely debated in Switzerland is the possibility for foreigners to take advantage of the opportunities provided by local law to commit suicide with the assistance of organizations. With regard to the Swiss regulatory regime, on July 7, 2009 the prosecutor of the canton of Zurich and EXIT Deutsche Schweiz signed an agreement on organized assisted suicide, which provides some rules to prevent professional abuse. Also note the opinion n. 13/2006 “Criteria of care in cases of assisted suicide”, approved by the CNE October 27, 2006, a number of recommendations concerning the investigations to be carried out prior to assisted suicide.

^h In the years 2001–2004 the percentage of people accompanied by EXIT Deutsche Schweiz to commit suicide who were not suffering from terminal illnesses is 34%. The results of this study are published in: S. Fischer, AC supply Huber, L. Imhof, R. Mahrer Imhof, M. Furter, S.J. Ziegler, G. Bosshard, “Suicide assisted by two Swiss right-to-day Organisations”, in Journal of Medical Ethics, 2008, 810–814.

freedom, assisted suicide as conceived by the public authority cannot be legally executed because it does not imply the right to a benefit from the State or to the aid of a third party.

The Court also declared that a lethal drug need not necessarily be prescribed merely because it is requested by a person, stating once again that certain conditions should be satisfied if committing suicide involves the help of a third party: it must be based on free will and take place after a medical examination conducted to ascertain the mental capacity of the subject. There is a crucial difference between the will to die expressed as a consequence of a mental disorder that can and should be treated, and the same will expressed by a subject who is mentally capable of such a decision. Both in Magri and Haas cases a clear wish to end life was expressed due to the consideration that life was not worth living.

4. Discussion

Suicide by human beings involves a broad spectrum of issues, including sociology, culture, anthropology, philosophy, morality, psychology and psychiatry.¹³ Despite in-depth reflection, none of these disciplines has ever been able to provide a fully satisfactory interpretation of suicide. According to Pavan 2009, all suicides, regardless of the underlying motives, are characterized by despair induced by experiences deemed to be catastrophic, by an inability to change or accept change, by an enigmatic component of dramatic grandeur, in which there is the denial of death at the very moment in which it becomes the present, and lastly by a growing impulsiveness that tends to prevail and overcome any residual resistance.¹⁴ These are, however, all psychological elements that do not necessarily fall within the psychiatric spectrum. Magri case reminds us how the process of medicalization of the death has opened new scenarios for the role of physicians involving in the care of mentally-ill patients. The practical difficulty in the judging the freedom of choice of a mentally-ill person who requests assisted suicide is based on the thin line that separates the freedom of choice a mentally-ill person has the right to and the extent to which that person's judgment is impaired by his/her mental illness.²²

The instability of the wish to die by euthanasia or assisted suicide in depressed patients and the possible incapacity to decide due to the depressive disorder warrant the inclusion of a thorough psychiatric evaluation among the procedures for assisted suicide and euthanasia.¹⁵ Such an evaluation is currently not obligatory but merely recommended in equivocal cases.¹⁶ As regards the importance of clinical evaluation, a significant example has been reported by the so-called "Dr. Chabot Case" where a psychiatrist, who helped a 54-year-old woman to commit suicide through a lethal mixture of sleeping pills, was deemed to have improperly applied the law on assisted suicide since no other doctor had been able to examine the patient. Although Dr. Chabot found no clinical evidence of major psychopathology and tried to treat the woman pharmacologically though unsuccessfully, he never made an independent psychiatry evaluation. Dr. Chabot was not found guilty of any crime but the local medical association reprimanded Dr. Chabot on the assumption that the intractability of the patient's condition had not been proved, stating that her refusal to be treated were typical symptoms of depression, and that he should have made a greater effort to persuade the woman to receive therapy.^{11,12}

Stating that patients suffering from major depression, which prevents them from seeing any future prospects and renders daily living intolerable, should have access to a form of assisted suicide is the next highly controversial step. Indeed, such a statement has ethical implications that must be carefully considered because it implies that suicide is acceptable in some cases of mental illness.

To choose to end one's own life entails denying that life is preferable to death whereas killing has exactly the opposite effect,

i.e. it assigns great value to life. Psychiatric practice in the West has in recent decades gradually introduced the belief that suicide is, almost always, an expression of a mental illness, supplanting the traditional idea of suicide in some Oriental cultures.^{17–19} Suicide is also perceived as a weapon of struggle, as Westerners have painfully found out over the last ten years, which has been used as such in other cultures for centuries.²⁰ However, when a person expresses a desire to die, one of the first questions that should be asked, if not the very first, is whether that person is capable of choosing freely and of judging. The principle of personal autonomy presupposes that decisions regarding one's own life should be respected, though only decisions taken by a person who is in full possession of his/her decision-making skills can be considered valid. Magri decided to end his life consciously and with a freely informed consent. Along with the legal and ethical difficulty to recognize per se the idea of rational suicide, some of the most complex concerns about the permissibility of assisted suicide may be how to prevent that this practice could be imposed or facilitated upon exposed people and how to establish the adequate time to allow patients to change their mind. In the Magri case, the main Italian newspapers reported that he tried to commit suicide others times before to do it definitely, though with no success. Scarce and poor details we found in this regard and, thus we have no perception of whether Magri changed his mind during the decision making process or not. However, we believe that further aspects should be considered in the assessment of the decision making process to commit suicide and, an interesting approach is the evaluation of time factor in the process of changing mind.

As regards the age factor, Muller et al. (1998) highlighted the negative effect that the practice of euthanasia and assisted suicide may have in several vulnerable groups such as the elderly, warning about the risk that this population may be victimized.²⁶

The mere presence of mental illness does not obviously mean a person is unable to express consent or dissent to treatment. If suicidal ideation is considered as an expression of a mental condition, it must be classified as pathological, which in turn means that a desire to commit suicide is invariably an expression of an inability to take decisions. However, according to this line of thought, we exclude the possibility of rational suicide, thus devaluing those cultures in which suicide is considered a spiritual act or ethically appropriate in certain circumstances. This interpretation of suicidal ideation would also place great responsibility upon psychiatrists.

If a person has an attack of acute psychosis, is confused or delusional, and intends to commit suicide, there is an ethical need to treat that person as is assumed that the mental condition precludes a free choice. In cases in which the person is subjected to a particularly degrading, humiliating or painful physical condition that mortifies that person's dignity, the intention to commit suicide may be associated with a chronic death wish. The psychiatrist's decision would in such cases be more complicated because the death wish is based on a permanent, not *acute/transient*, condition in a person's life. The psychiatrist is thus forced into an awkward position in which he/she must, on the one hand, respect the patient's freedom, trying to avoid using strong measures at his/her disposal, such as the Compulsory Health Care and, on the other hand, must prevent the patient from harming him/herself.

How should one behave ethically in such a confined position? The moral distinction usually made between acts and omissions for suicide prevention purposes is not, unfortunately, effective. Indeed, in the medical field there is marked difference between not administering antibiotics to a terminally-ill patient who has developed pneumonia, which is ethically acceptable, and providing drugs required to die. In the field of psychiatry, by contrast, a psychiatrist who does not treat a patient who expresses a desire to

commit suicide is guilty of medical misconduct since the patient is allowed to intentionally kill him/herself and does not die as a result of the natural course of a disease, as occurs in general medicine.

The psychiatrist can thus expect little help from the existing laws when faced with a patient with a suicidal desire. Moreover, treatments in psychiatry are, unlike those adopted in surgery and many medical specialties, not very expensive, sometimes merely consisting of physical restraint of the patient by means of surveillance or confinement in seclusion rooms (or, as occurred in the past, of neurosurgical lesional therapies or experimental drugs). This, however, implies total control over people's physical freedom. Such conduct is, thankfully, considered inhumane and is perceived as the annihilation of what life patients undergoing such treatment have left. It is, nevertheless, indisputable that self-inflicted death is not a natural course of events and that it cannot be accepted passively.

In Italy, a patient can overtly express an intent to commit suicide, can be seen by a psychiatrist who proposes treatment aimed at avoiding suicide, can agree to be treated, declaring in writing that the intent to commit suicide was not genuine. The psychiatrist cannot consequently resort to legal coercive measures to prevent suicide. From a technical point of view, although the psychiatrist may, in such cases, be fully aware that the patient intends to carry out his/her intent to commit suicide, he/she does not contravene the law by favoring the abandonment of the patient. What may not be considered is the fact that from a subjective point of view the majority of suicides are rational decisions that have been taken freely. An clear example of an irrational suicide is that of a patient suffering from paranoid schizophrenia with hallucinations, though suicides of this type are very rare and few schizophrenics kill themselves for such reasons. Suicides are rational when considered from an existential perspective. If, however, a psychiatric patient comes to an irreversible decision, the level of rationality must be very high. Although the choice to commit suicide may in some cases be ethically understood, it cannot be condoned from the medical ethics and legal points of view. However, even if we do consider the right to die with dignity as an expression of the right to live, i.e. as a "fundamental right" of mankind, it must be borne in mind that the ability to think rationally in a seriously depressed person who is not treated or refuses treatment is impaired by the disease itself.

5. Conclusions

From an ethical point of view, assisted suicide is difficult to endorse within a context that supports the broadest possible decision-making autonomy but, at the same time, requires a level of rationality and judgment that reconciles what Rawls calls "reasonable disagreements". Judging, which means defending a standpoint, cannot be separated from the underlying sentiment. Depression is a mental condition that unintentionally distorts a person's humor and the way that person perceives the world, thereby altering life's deeper meaning. However, rational and logically formal one is, the human perspective resulting from depression is such that it prevents consciousness from conceiving any future. Under these conditions, what is the likelihood of a person being able to clearly understand that one option is actually the lesser of two evils? In the absence of a clear legal system and in the presence of a diversified common feeling, the ultimate decision can only be based on a personal conviction, which one cannot however expect the physician to share unconditionally. In existential terms, suicide, even in a situation of intractable depression, may perhaps be interpreted as a horizon of possibility. Ethics and the law cannot accept a principle that eliminates the difference between the mind and body, ruling that the depression is equal in rank, in terms of human suffering and irreversibility of the

treatment, to a terminally-ill person with intractable pain. Indeed, the acceptance of such a principle would destroy the bond of social solidarity with the depressed, thereby exposing other patients with a similar mental condition to discrimination; this would consequently eliminate the fundamental distinction between the loss of hope caused by imminent death and painful somatic illness and the depression-induced idea that life is not worth living.

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